Hospital Discharge Data Information Form
Report to the Arizona Department of Health Services

Facility Name: _____

Reporting Period: _____   Due Date: _____

Discharge Data File Reporting Names (use Standard Naming Convention outlined below):

Hospital Inpatient (**file type IP**):   _____

Hospital Emergency Department (**file type ED**):   _____

Standard Naming Convention: [facility ID]_[file type]_[reporting period]

EXAMPLE: MED1234_IP_2004-01

    -MED1234 is the provider facility's state issued facility ID number.
    -IP is the file type code for a hospital inpatient data submission file.
    -2004-01 is the first half of 2004, January through June reporting period.

1)   Provider Facility's Arizona State Issued Facility ID Number: _____

2)   Provider Contact Person's Name: _____

3)   Contact Person's Address: _____

4)   Contact Person's Phone Number: _____

5)   Contact Person's E-mail Address: _____

If the organization responsible for submitting the Discharge Data Reports is different from the Provider Organization, ALSO provide the following:

6)   Data Submission Organization Name: _____

7)   Contact Person's Name: _____

8)   Contact Person's Address:_____

9)   Contact Person's Phone Number: _____

10)   Contact Person's E-mail Address: _____